COMMUNITY BEFORE & AFTER SCHOOL
CHILD CARE PROGRAM (CAP)

MEDICATION AUTHORIZATION FORM

Child Information

Child's Full Legal Name		Nickname	
Date of Birth		Age	☐ Male ☐ Female
School Attending in Fall		CAP Site	
Home Address		City	Zip
Home Phone	Cell Phone	Work Phone	

Medication Information

Medication	Dosage
Purpose	
Times to Dispense	
Date to Begin Dispensing	Date to End Dispensing
Possible Side Effects/Special Instructions/Precautions	
Prescribing Physician Name	Physician Phone

Instructions

Medication shall be available with the child's name, the name of the medication, the dosage amount and the time or times to be given (listed on page 2). Prescription medication shall be in the original container with the prescription label attached. Medication shall be returned to the parent as soon as the medication is no longer being administered. If medication is not picked up it will be discarded. Long-term prescription drug use may be allowed with written authorization from the child's physician and parent/guardian. Verification chart of medication administration is on the reverse of this sheet.

In-Service and Vacation Days

IMPORTANT: During In-Service and/or Vacation days parents/guardians are responsible for the transfer of prescription or non-prescription medications to the appropriate CAP site. CAP will not be held liable for any missed doses/medication.

Agreement

I hereby give my permission for my child to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication and bring it to school. I hereby request that my child be given the above medication while at CAP. I understand that non-medical personnel may give the medication. I understand that medication administration will not begin until this form is on file and personnel have received instruction concerning administration of medication. I further understand and agree that the Community Before & After School Child Care Program, its officers, agents, and employees are not responsible for any effects of the medication administered. I understand that I must notify the school in writing of any changes in my child's condition, medication, or dosage. I further understand that I am responsible for ensuring that medication safely arrives at school and for providing refills of the medication as indicated.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

"The USDA and the State of Oregon are equal opportunity providers and employers."

PRESCRIPTION MEDICATION
ADMINISTRATION VERIFICATION CHART

Child's Name							CAP Site				
Time	**Date**	**Dosage**	**Staff**	**Time**	**Date**	**Dosage**	**Staff**	**Time**	**Date**	**Dosage**	**Staff**

ATTENTION CAP STAFF MEMBERS:

Please be sure to communicate with Parents/Guardians the proper transfer of medications during Non-School days per the CAP policy.

CAP POLICY: During in-service and/or vacation days parents/guardians are responsible for the transfer of prescription or non-prescription medications to the appropriate CAP site. CAP will not be held liable for any missed doses/medication.